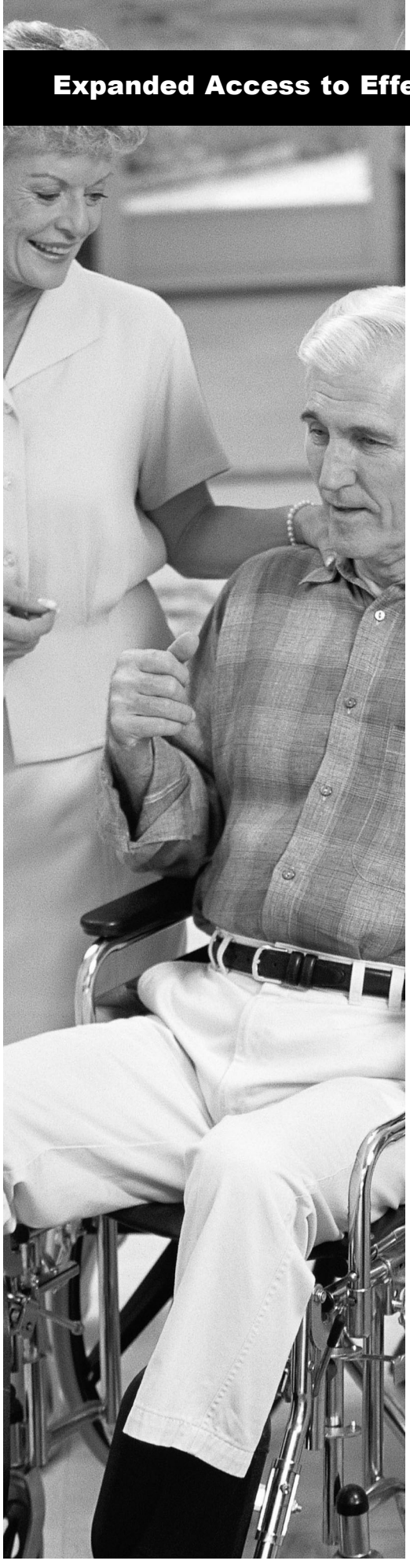


Expanded Access to Effective Health Care Services

HHS is the largest purchaser of health care in the world, administering Medicare, Medicaid, and the State Children's Health Insurance Program. Outlays for these programs, including state funding, represent 33 cents of every dollar spent on health care in the United States.

Millions of Beneficiaries

Individualized Service

While HHS covers millions of beneficiaries and outlays more than $350 billion per year on our health insurance programs, we are striving to ensure that all beneficiaries have unfettered access to our programs and that they are provided with quality health care services. One of our main objectives is to improve the health and satisfaction of beneficiaries in our programs. This includes educating beneficiaries, improving Medicare services, and using research and oversight to protect beneficiaries from substandard care. We are also striving to promote fiscal integrity in our programs to the greatest extent possible. Additionally, we seek to increase the availability of health care services for America's underserved populations, including American Indians and Alaskan Natives.

Improved Services through Re-organization

An initiative was undertaken by Secretary Thompson this year to reform and strengthen the services and information available to our beneficiaries and the health care providers who serve them. As part of that effort, Secretary Thompson unveiled the new name for the HHS component that runs the Medicare and Medicaid programs - the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration. The new name reflects the increased emphasis at HHS on responsiveness to beneficiaries and providers, and on improving the quality of care that beneficiaries receive in all parts of Medicare and Medicaid.

To achieve these goals, the Centers for Medicare & Medicaid Services launched a national media campaign to give seniors and other Medicare beneficiaries more information and restructured CMS around three centers that reflect the agency's major lines of business.

An initiative was undertaken by Secretary Thompson this year to reform and strengthen the services and information available to our beneficiaries and the health care providers who serve them.

CMS will use major television, print, and other media to reach out and share information and educational resources to all Americans who rely on Medicare, their families, and their caregivers. CMS also plans many other future changes that will make CMS more responsive to the needs of the beneficiary population.

HHS leadership has also worked with the White House to develop principles for strengthening and improving Medicare. HHS also developed a Prescription Drug Card as part of our comprehensive Medicare Prescription Drug plan.

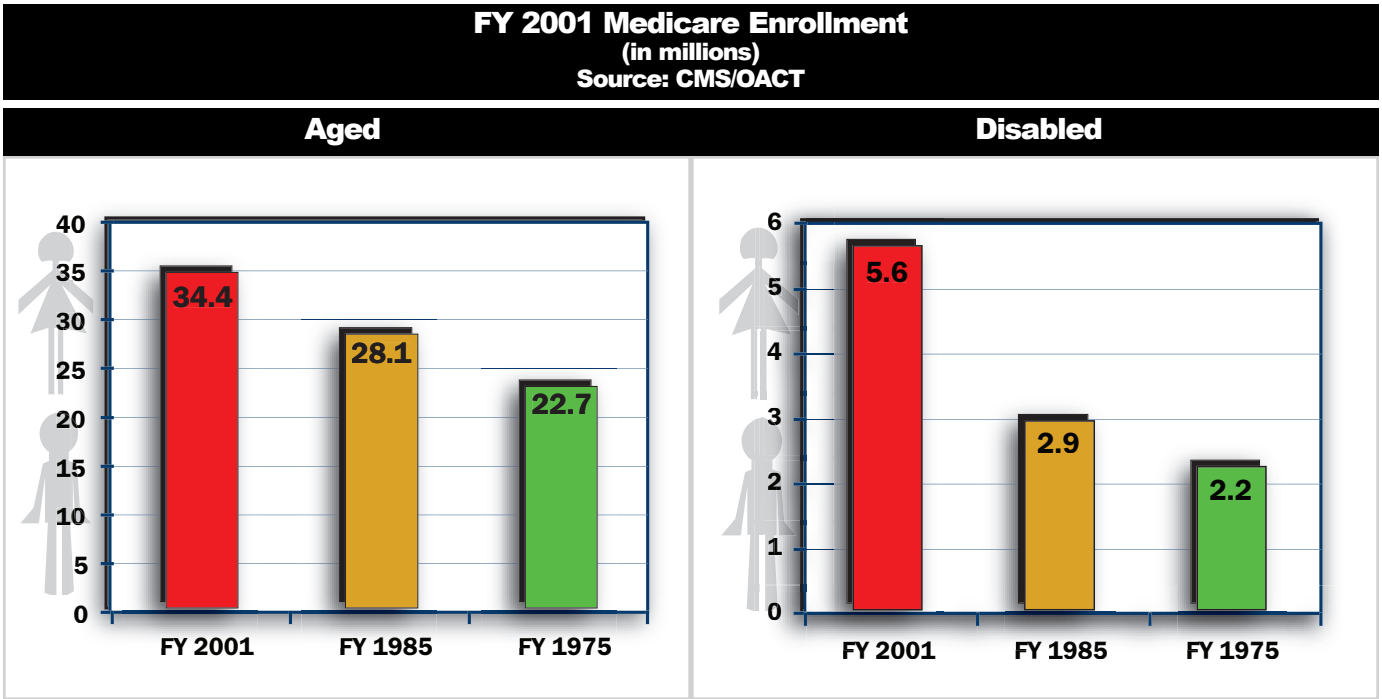
Medicare, Medicaid, and Medicare+Choice

HHS, working through CMS and the Medicare contractors, is the nation's largest health insurer, providing coverage to 40 million Medicare beneficiaries as well as 34 million Medicaid enrollees in conjunction with the states. Medicare alone processes 930 million claims each year, for some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers.

Comprehensive Coverage

Medicare covers both hospital insurance and insurance for physician and outpatient care, laboratory tests, skilled nursing facility care, home health care, durable medical equipment, designated therapy services, and other services not covered by hospital insurance. Medicare+Choice was created in 1997 to increase health care options for beneficiaries through a greater variety of managed care and fee-for-service plans. With these programs, over the last 30 years, Medicare has significantly contributed to increased life expectancy, a better quality of life, and protection from poverty for the aged and disabled.

Medicaid is the primary source of health care for medically vulnerable Americans such as poor families, the disabled, and persons with developmental disabilities requiring long term care. Medicaid is administered in partnership with the states. States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines. States have a great deal of programmatic flexibility to tailor their Medicaid programs to individual state circumstances and priorities. HHS issues the matching payment grants to states and territories for medical assistance and administrative costs. Medicaid has improved birth outcomes, childhood immu-



One of HHS' central concerns is that Medicare beneficiaries are able to get the care they need when they want it, and that they are not impeded by such factors as cost, health status, location or the availability of health care support networks.

nization rates, and access to preventive services, resulting in overall improvements in the health of America's children.

One of HHS' central concerns is that Medicare beneficiaries are able to get the care they need when they want it, and that they are not impeded by such factors as cost, health status, location or the availability of health care support networks. Certain subgroups, such as minorities, persons with disabilities or individuals without health care insurance, are particularly vulnerable to substandard or nonexistent medical attention.

We Have Increased Dual-Eligibility Enrollment

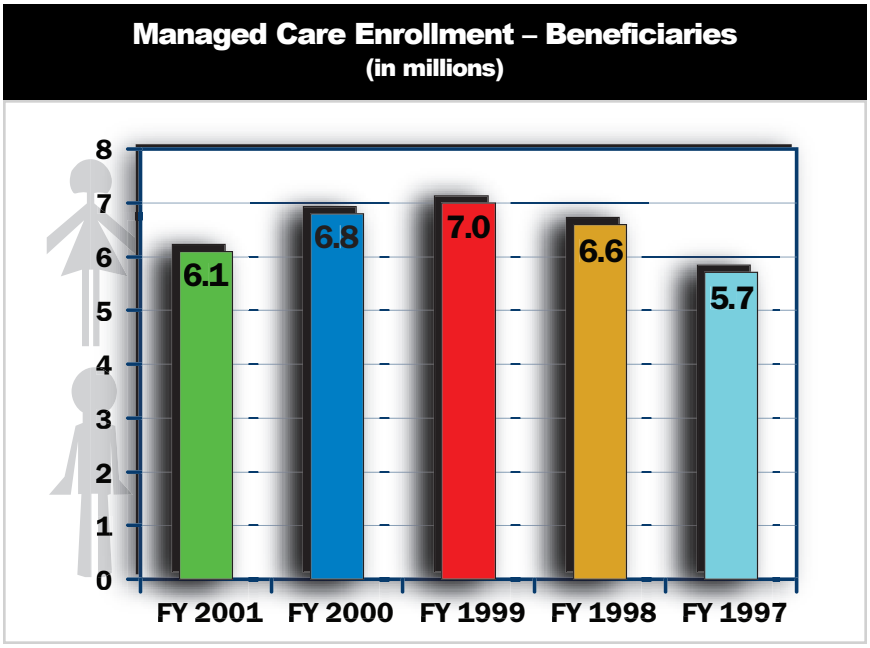
HHS has expanded access to the dual-eligibility programs of Medicare and at least some aspects of Medicaid, to ensure that low-income Medicare beneficiaries get assistance with cost-sharing expenses. In essence, low-income Medicare beneficiaries have some of their cost sharing (coinsurance and deductibles) paid for by their state. This increases potential access for those beneficiaries, as they will not defer medical treatment for financial reasons. HHS has worked with federal agencies and states to raise awareness of the dual eligibility program, leveraged improvements through grants to states, sponsored regional training sessions and developed resource guides to help expand the program and, thereby, enroll more beneficiaries.

The performance goal for this section focuses on reducing financial barriers to care by increasing the enrollment of individuals who are dually qualified for Medicare and at least some aspects of the Medicaid program. Our emphasis in the initial years of this goal was on increasing enrollment for Medicare beneficiaries eligible for the Qualified Medicare Beneficiary or the Specified Low-Income Medicare Beneficiary programs. We surpassed our FY 2000 target and increased enrollment in dual eligible programs by 4.4 percent, with 5,499,349 dual-eligibles enrolled. Due to the overwhelming success of so many states in FY 2000, we modified our approach to measuring this area for FY 2001. Instead of setting a goal to achieve a national rate increase of 4 percent, we are focusing on states that received CMS grants for outreach activities and states that did not meet the FY 2000 national target.

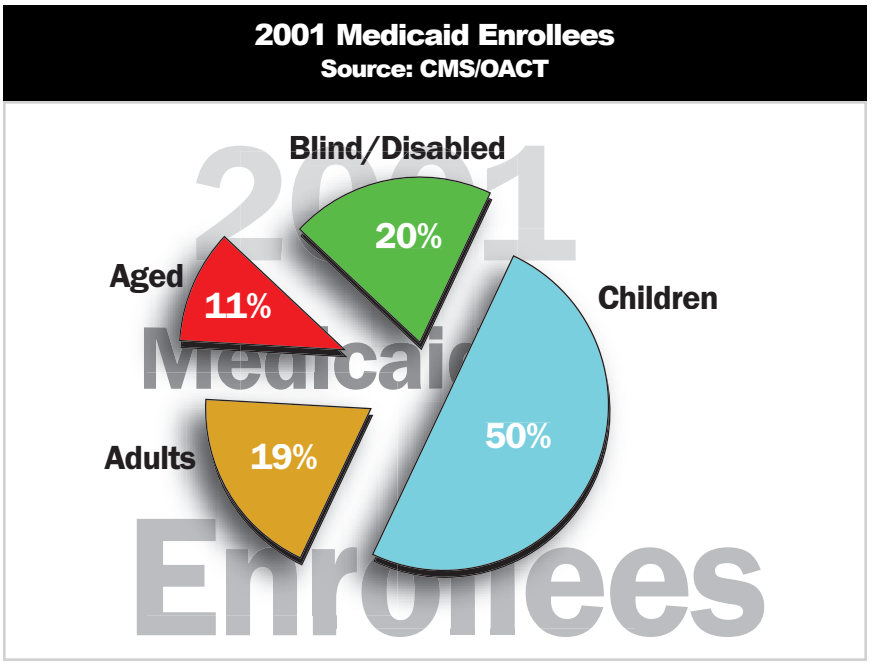
Interim FY 2001 data indicate states are making progress in adding enrollees. Additionally, CMS implemented a strategy for increasing enrollment of dual eligible populations that was established as part of the FY 1999 performance plan that called for an increase in partnerships with a variety of public and private agencies.

Access to Medicare services continues to be a challenge that HHS leadership has focused on intently. While we have made strides in many areas, as noted above, there have been other developments that have made the broader access goal more difficult to achieve. In particular, the Medicare+Choice program, to this point, has not grown the way some have projected.

Medicare+Choice was established by the Balanced Budget Act of 1997 (BBA) to increase health care options for beneficiaries through a greater variety of managed care and fee-for-service plans. Unfortunately, the last three years have seen health plans restrict their service areas



Important cost-sharing protections also were established so families would not be burdened with out-of-pocket expenses they could not afford.



or pull out of Medicare altogether. The total number of Medicare managed care contracts has declined from 455 in FY 1998 to 251 in FY 2001. While many beneficiaries have other health plans available to them in their service areas, there has been, at minimum, disruption for those beneficiaries. For the current plan year, 536,000 beneficiaries were affected by plan withdrawal. Of that total, 446,000 or 83 percent, had another managed care plan in their service area. For the remaining 90,000 they would always have fee-for-service, the original Medicare plan, available.

HHS has continued to assist states in promoting the opportunity for eligible children to enroll in Medicaid. Among our efforts, we asked states to review their outreach efforts and eligibility processes to ensure that as many eligible families and children as possible are given the opportunity to enroll in the program. We also asked states to reinstate anyone who may have been improperly terminated from the program.

SCHIP

One of our most important new initiatives has been the implementation of the State Children's Health Insurance Program (SCHIP). SCHIP was created in 1997 in the BBA to address the fact that nearly 11 million American children - one in seven - were uninsured and therefore at significantly increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid.

Congress and the Administration agreed to set aside $24 billion over five years, beginning in FY 1998, to create SCHIP - the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage.

Important cost-sharing protections also were established so families would not be burdened with out-of-pocket expenses they could not afford. HHS is working closely with states and the Congress to fulfill the challenges inherent in designing and implementing an ambitious new program such as SCHIP. Additionally, HHS has granted numerous waivers and state plan amendments to states that will increase access and expand benefits to both Medicaid and SCHIP. The coverage areas include enhanced cervical and breast cancer coverage and community long term care alternatives to institutions.

The implementation of SCHIP has been driving enormous change in the availability of health care coverage for children and in the way government-sponsored health care is viewed and delivered. The energy invested by states, communities, and the federal government in the SCHIP initiative has resulted in significant expansions in coverage as well as new systems for enrolling children into publicly funded coverage programs.

Our goal is to increase the number of children (up to age 19 for SCHIP; age

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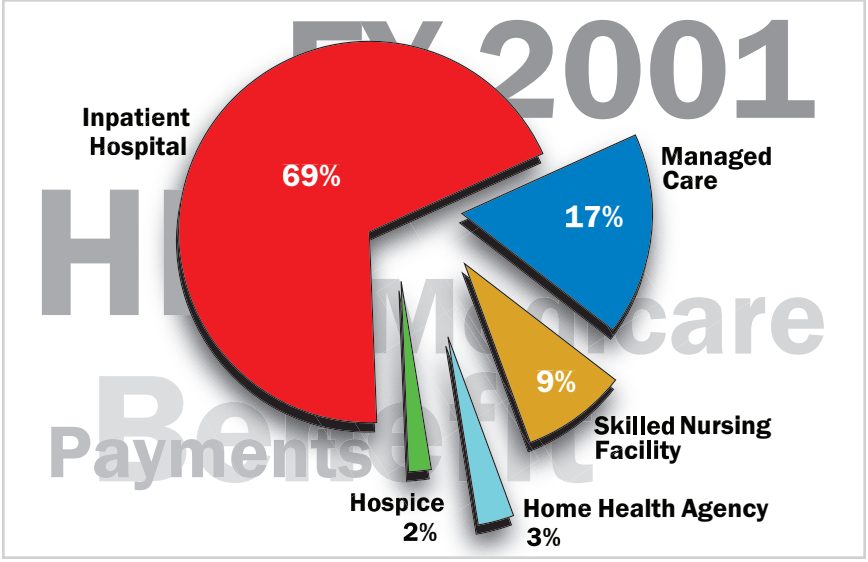
21 for Medicaid) who are enrolled in regular Medicaid or SCHIP by one million over the previous year's level. As of FY 2000, there were approximately 23,659,000 children enrolled in SCHIP and Medicaid, which exceeded our FY 2000 target. Due to the overwhelming support for the program, we anticipate continued success for our goal to increase enrollment by one million in FY 2001.

We Improved the Fiscal Integrity of Medicare and Enhanced the Value of Services Purchased for Beneficiaries

HHS recognizes the importance of ensuring the integrity of its health care programs in order to improve services, provide the best value to beneficiaries, and to eliminate fraud and abuse. HHS works to achieve these important objectives in a number of ways which include managing programs to improve quality and competition in health care programs, developing and disseminating checklists for use in the review of states' managed care contracts, and developing new payment systems that can improve services and reduce improper payments.

One of the major issues on which HHS has focused its attention is the accuracy of payments in Medicare. In recent years, HHS has made substantial progress in reducing the error rate and improper payments in the Medicare program, a critical aspect of providing strong services and maintaining stewardship over tax dollars.

FY 2001 HI Medicare Benefit Payments
Source: CMS/OACT



HHS' goal is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Medicare's fee-for-service program is one area in which HHS has taken increasingly strong actions in recent years. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

The complexity of Medicare payment systems and policies, and the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. HHS has implemented a Corrective Action Plan designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate.

Our objective is to reduce the percentage of improper payments made under the Medicare fee-for-service program. We have made substantial progress over the years, from 14 percent in FY 1996, to 6.3 percent in FY2001. This compares to our FY 2001 target of six percent. In general, the substantial reduction in the error rate since FY 1996 demonstrates that the Medicare contractor claims processing system is working well.

HHS is also committed to assisting interested states in developing methodologies and conducting pilot studies to measure and ultimately reduce Medicaid payment error rates. HHS established with the American Public Human Services Association a National Medicaid Payment Accuracy Workgroup to help define, guide, and coordinate this federal-state collaborative project.

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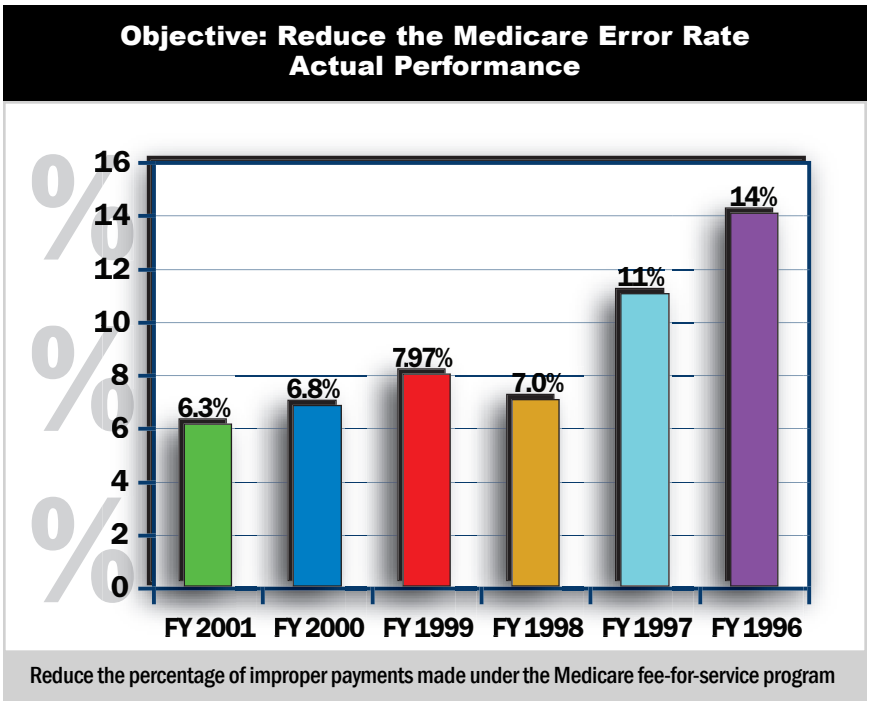

Information was collected on the significant Medicaid payment accuracy studies conducted to date (by Illinois, Texas, and Kansas), and discussions were initiated with several states that might be interested in participating in the pilot studies. Moreover, HHS is educating beneficiaries to identify and report instances of fraud, and implementing the Comprehensive Error Rate Testing program to produce contractor, benefit specific, and national error rates.

Increase the Potential for Living

Another way to ensure that we use all of our precious resources to their utmost is to focus on maximizing organ donation. HHS launched a new national initiative to encourage and enable Americans to "Donate the Gift of Life."

The need for organs for donation is growing almost twice as fast as the supply. In 1990, about 15,000 organs were transplanted while the number of persons on the list needing an organ totaled almost 22,000. According to the United Network for Organ Sharing, 22,827 organs were transplanted last year (a 5.3 percent increase over 1999), while the list of those needing a transplant has grown to more than 76,000 (a 10.2 percent increase in 2000).

Initial steps in the campaign included the launch of a national "Workplace Partnership for Life," in which employers, unions and other employee organizations will join in a nationwide network to promote donation. Secretary Thompson also released a model organ and tissue donor card, incorporating proven elements from today's donor cards. But at the same time, he said that donor cards alone are not enough to enable Americans to be sure their wishes for donation will be known and carried out. Therefore, he ordered an immediate review of the potential of organ and tissue registries where donors' wishes could be recorded electronically and made available to families and hospitals whenever needed.

HRSA will devise a new goal to measure how effective this new campaign is as we move into the future. The challenge will arise as we attempt to honor donors' wishes as well as make the donor information usable to medical organizations in real time, so that more organs can be used to save lives.

Providing Basic Health Care Needs

For more that 30 years, Health Centers, as part of America's health care safety net for the

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nation's indigent populations, have provided community-based, cost-effective, and comprehensive primary and preventive health care to many homeless, underserved, low-income and minority populations. These centers are family oriented and provide usual and regular access to high quality health care, regardless of individuals' ability to pay, which significantly improves the status of their patients.

In FY 2001, Health Centers treated 10.5 million patients at more than 3,000 sites. However, as the Health Center program increases in size, it continues to face considerable pressure because Centers frequently are the only safety net providers who serve low income, uninsured patients. This is a significant financial burden for the centers, as many of these patients cannot afford to pay much, if anything, for their health care. In FY 2000, 40 percent of Health Center patients were uninsured.

Our goal for this section is to assure access to preventive and primary care for minority individuals in the Health Centers (racial minorities). For FY 1999, 5.79 million minority individuals were seen in the Health Centers. In FY 2000, 6.49 million were seen, surpassing the goal of 6.24 million for that year. The goal for FY 2001 is 6.83 million minority individuals, with data expected later in FY 2002.

Cost Effectiveness of Health Care

Americans spend more on health care than any other country in the world today. In FY 1999, National Health Expenditures reached $1.2 trillion. In addition, as a country we spent 13 percent of GDP on health care. Given those figures, it is imperative that we utilize the most cost-effective sites when we receive health care. According to a Health Center Medicaid Beneficiary study, reductions in Medicaid costs for a comparable group seeking health care elsewhere range from 30-34 percent. In addition, Health Center Medicaid patients are 22 percent less likely to be inappropriately hospitalized than Medicaid beneficiaries who obtain care elsewhere.

The challenge in this area is to continue to provide services to a largely uninsured, minority, and low-income population when our Health Center sites are extremely vulnerable to the market-driven downward pressure on revenues.